

**SENATOR JOHN B. BREAUX**

**RANKING MINORITY MEMBER**

**SENATE AGING COMMITTEE**

**"Improving Accountability in Medicare Managed Care: the Consumer's  
Need for Better Information"**

**Opening Statement**

**Thursday, April 10, 1997**

Thank you, Mr. Chairman.

The issue before us this morning is that many Medicare beneficiaries simply don't know how managed care is different from "standard" fee-for-service Medicare or what the differences between the Medicare Health Maintenance Organizations (HMO's) in their local areas are. In addition, it is generally agreed that in order for HMO's to serve their enrollees well, they must compete on more than just price as they do now. Providing Medicare beneficiaries with more and better information than they now have will help with that goal.

While the vast majority of Medicare beneficiaries--87 % nationally--remain enrolled in traditional fee-for-service Medicare, this is changing rapidly. The number of beneficiaries nationwide who enroll in HMO's is growing by about 30% annually. In Louisiana, the growth rate exceeds 50 %. The number of health plans with Medicare contracts is also increasing rapidly. In 1993, there were 110 such plans. By the end of last year, the number had more than doubled to 241.

This morning, we will focus specifically on Medicare's role as the supplier of HMO information and ways it should be improved. We will also look at how other large purchasers educate their beneficiaries about managed care options, and the General Accounting Office (GAO) will offer some specific ways beneficiaries can be supplied with better information.

In addition to the GAO, there are other groups which have studied the whole issue of how Medicare beneficiaries receive information on the health plans available to them and the quality of that information. The Prospective Payment Assessment Commission, for example, stated in its most recent report that "cost and benefit definitions should be standardized so that beneficiaries can better compare plans."

The Institute of Medicine last year reported that "current information available to Medicare beneficiaries lags far behind the kinds of assistance provided by progressive private employers to their employees."

Mr. Chairman, while we are focused this morning on a very specific consumer issue, I want to strongly reiterate the strong need for comprehensive, bipartisan Medicare reform. It is important that we not lose sight of that goal. I am strongly supportive of using the Federal Employee Health Benefits Program (FEHBP) as a model for broad Medicare reform. As I stated at our Finance Committee hearing on

March 19, "nip-and-tuck" methods of Medicare reform only postpone the real reforms that are necessary to save the program from bankruptcy. I called for a fundamental shift by possibly infusing a significant portion of the FEHBP into Medicare. While such a shift is not really our focus this morning, I think FEHBP's plan-selection process, combined with better beneficiary information, could provide Medicare beneficiaries with the tools they need to make informed choices based on cost and quality of care.

One logical answer to certain structural questions posed by Medicare reform appears to lie in providing more and better information so that beneficiaries can make informed choices. It's really a fairly simple concept, but one that government often loses sight of: people make wiser and less costly decisions for themselves and their families if they have the right kind and right amount of information.

I am particularly pleased with the impressive group of witnesses and experts we have with us here today. I trust they will shed some valuable light on how we are doing with regard to providing Medicare recipients the information they need to make informed choices; how we can improve on our efforts; and how we can provide the best quality information possible.

Thank you, Mr. Chairman.